92-1785

Supreme Court, U.S.
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Case No. _____

In the United States Supreme Court

October Term, 1992

IHC Hospitals, Inc., Charles L. Doane, Merrill C. Daines, Lee S. Broadbent, Robert L. Jensen, C. Chris Friess, and Charles T. Swallow,
Petitioners

v.

Joseph F. Decker, Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit.

Petition for Writ of Certiorari.

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QUESTIONS PRESENTED FOR REVIEW.

1. Whether the court of appeals erred in holding that the qualified immunity created for hospital peer review participants by the federal Health Care Quality Improvement Act of 1986 (42 USC Sec. 11101 et seq.) ("HCQIA"), is mere immunity from liability, from which an interlocutory appeal cannot be taken, or whether it should have held that HCQIA creates qualified immunity from suit, so that the court of appeals would have considered the substance of petitioners' interlocutory appeals seeking to vindicate their statutory immunity after the district court denied petitioners' motions to dismiss.

2. Whether the holding of the court of appeals is inconsistent with the characterization of HCQIA immunity in the case Summit Health Ltd. v. Pinhas, 111 S. Ct. 1842, 1848 n. 12 (1991).

PARTIES TO THE PROCEEDING.

The names of all of the parties to this proceeding in the United States Court of Appeals for the Tenth Circuit are listed in the caption to this case. Amicus curiae briefs were submitted to the court of appeals in support of the position of petitioners by the American Hospital Association, the Utah Hospital Association, and the Utah Medical Association.

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DECISIONS IN THE COURTS BELOW.

The decision of the United States Court of Appeals for the Tenth Circuit in this case is reported as Decker v. IHC Hospitals, Inc., 982 F. 2d 433 (10th Cir. 1993), and is reproduced in Appendix B. The decision of the district court from which that appeal was taken is not reported. See, Decker v. IHC Hospitals, Inc., Civil No. 91-C-424 G, United States District Court for the District of Utah, Central Division.

GROUNDS UPON WHICH JURISDICTION IS INVOKED.

The decision of the court of appeals dismissing petitioners' appeals was filed December 29, 1992 (Appendix B), following which the petitioners all petitioned the court of appeals in a timely manner for a rehearing and a rehearing en banc. The petition was denied in an order of the

court of appeals dated February 11, 1993 (Appendix C). Pursuant to Rule 13 of the Rules of the Supreme Court of the United States, this petition is filed within 90 days after the denial of the petition for rehearing. Jurisdiction for the Supreme Court to hear this case exists pursuant to 28 USC Sec. 1254(1) (review by writ of certiorari of cases in the courts of appeals).

STATUTES INVOLVED

This case involves the interpretation of the Health Care Quality Improvement Act of 1986, 42 USC Sec. 11101 et seq, as amended, the relevant sections of which are reproduced in Appendix A. The proper application of that Act to litigation such as this has never been considered by the U.S. Supreme Court.

STATEMENT OF THE CASE

In 1986, Congress passed the Health Care Quality Improvement Act, 42 USC Sec. 11101 et seq., (herein "HCQIA" or the "Act")[1] for the expressed purpose, among others, of "provid[ing] incentive and protection for physicians engaging in effective professional peer review." The Act was passed to address an "an overriding national need" that had created a "nationwide problem." That problem was the ability of "incompetent physicians" to move around the country without disclosing professional disciplinary actions taken against them. Such incompetent physicians would hurt someone, be professionally disciplined by a hospital, move on to a new city and a new hospital, lie about their background to the new hospital, hurt someone in the new hospital, following which the process

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1. The relevant portions of the Act are reproduced in Appendix A.

would repeat. Congress recognized that the problem could only "be remedied through effective professional peer review" (42 USC Sec. 11101), plus implementation of a national, centralized clearing house of information on professional disciplinary actions and payments made to satisfy malpractice claims.[2] The means chosen by Congress to provide the needed incentive and protection for professional peer review was a statutory grant of qualified immunity from damage liability claims for persons and institutions engaged in peer review activities that satisfy standards that are set forth in HCQIA. 42 USC Sec. 11111(a). The Act provides that hospital peer review activities are "presumed to have met the [procedural] requirements" of the

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2. HCQIA establishes what is known as the National Practitioner Data Bank to accumulate and disseminate information on both professional disciplinary actions taken against physicians and malpractice claims paid on behalf of physicians. See, 42 USC Sec. 11131 et seq.; 45 CFR Part 60 (1989).

Act, and thus, are presumed to be entitled to the Act's immunity, "unless the presumption is rebutted by a preponderance of the evidence." 42 USC Sec. 11112(a)(last sentence).[3]

Logan Regional Hospital is a licensed hospital owned by petitioner IHC Hospitals, Inc. and is located in Logan, Utah (herein the "Hospital"). The individual petitioners are the administrator of the Hospital (Mr. Doane), its medical director who is an employee of the Hospital (Dr. Daines), and individual physicians on the Hospital's medical staff but in private medical practice (i.e., they are not employed by the Hospital), who participated in various aspects of the peer review process involving Dr. Decker (Dr.s Broadbent, Jensen, Friess, and Swallow).

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3. The Act further provides that a failure to satisfy the procedural standards related to immunity in the Act "shall not, in itself, constitute failure to meet the [procedural] standards" for immunity. 42 USC Sec. 11112(b)(last sentence).

Respondent Dr. Joseph Decker (herein "Dr. Decker") has asserted multimillion dollar damage claims against all the petitioners for state and federal antitrust violations, state and federal RICO violations, fraud, extortion, and various other state and federal claims.

Dr. Decker's claims are all alleged to have arisen as the result of a peer review action involving Dr. Decker at the Hospital.[4] That peer review action was the result of the Hospital following its regular medical staff peer review and quality assurance processes. Based on concern for patient safety, in November, 1990, the Hospital imposed specified restrictions on Dr. Decker's Hospital privileges but it did not terminate any of his privileges. The restrictions were imposed for

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4. Dr. Decker's Amended Complaint purported to invoke the jurisdiction of the district court pursuant to 18 USC Sec. 1964, and 28 USC Sec.s 1331, 1337(a), 1343(a), and 1355, and it asserted pendant and ancillary jurisdiction over all non-federal claims.

the express purpose of improving the quality of health care available from Dr. Decker to patients in the Hospital. The main restriction involved the requirement that Dr. Decker obtain a consultation with another surgeon before performing non-emergency surgery in the Hospital.

This action was filed in the United States District Court in Salt Lake City, Utah, in April, 1991, approximately midway through the Hospital's internal hearing and appeal processes that were instituted at Dr. Decker's request to permit him to challenge the restrictions. Respondent's complaint and amended complaint request only money damages and not declaratory or injunctive relief related to the restrictions.

On the basis of HCQIA's immunity provisions, the defendants (petitioners herein) all moved the district court to dismiss Dr. Decker's action on the basis of his failure to exhaust the

Hospital's remedies and his failure to specifically and particularly allege facts which, if true, would overcome the statutory immunity for damage claims that is presumed under HCQIA to exist for participants in hospital peer review activities.[5] The individual physician defendants also moved to dismiss Dr. Decker's state law claims under Utah immunity statutes intended to protect and encourage peer review.[6] In an unpublished order

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5. Under HCQIA, there is a presumption that the statutory conditions for immunity have occurred. 42 USC Sec. 11112(a) (last sentence). Rule 8(c), Fed. R. Civ. P., requires that "A denial of performance or occurrence shall be made specifically and with particularity." Thus, a plaintiff asserting damage claims covered by HCQIA should be required to satisfy the Rule 8 "heightened pleading" standard in order to demonstrate that the statutory conditions for immunity have not occurred so that the case should be allowed to proceed past the initial pleading. Compare, Leatherman v. Tarrant County Narcotics etc., ___ U.S. ___, 61 USLW 4205 (March 3, 1993).

6. Utah Code Anno. Sec. 58-12-43(8): "An individual who is a member of a hospital administration, board, committee, department, medical staff, or professional organization of health care providers ... is immune from liability arising from participation in a review of a health care provider's professional ethics, medical competence, moral turpitude, or substance abuse."

(and without elaboration), the district court denied the motions to dismiss and directed the defendants to file answers and to proceed with discovery without regard to the immunity claims.

The defendants all appealed the denial of their motions to dismiss to the United States Court of Appeals for the Tenth Circuit. The jurisdictional basis of the appeal was that the statutory immunity in HCQIA was essentially the same as the qualified immunity of government officials from which such an interlocutory appeal would be allowed under the "collateral order exception" to the "final order" rule, as that rule is applied in qualified immunity cases such as Mitchell v. Forsyth, 472 U.S. 511 (1985). The substantive issue in the appeals was whether the failure of the district court to grant the motions to dismiss effectively deprived the defendants of the major benefit of the HCQIA

immunity that Congress intended them to have under such circumstances.

Dr. Decker moved to dismiss the appeal and that motion was reserved for decision until after briefing and oral argument. Following briefing and oral argument, the court of appeals ordered the appeal dismissed for lack of jurisdiction on the basis that HCQIA creates only immunity from liability, which does not support an interlocutory appeal, and not immunity from suit, from which an appeal would be allowed. See, Decker v. IHC Hospitals, Inc., 982 F. 2d 433 (10th Cir. 1993) (Appendix B).

The consequence of the opinion is that the qualified immunity exception to the collateral order rule was determined not to apply to the denial of a motion asserting HCQIA immunity and, thus, the district court's interlocutory order which failed to recognize the HCQIA immunity was determined not to be appealable until the end of the case, after

discovery and trial. As the result, petitioners must now fully litigate the plaintiff's claims from which petitioners are presumed by law to be immune, with no opportunity to challenge the district court's failure to recognize that immunity until after petitioners have absorbed the full burden and expense of the litigation.

This petition follows within 90 days after the order of the court of appeals denying the petitions for rehearing.

REASONS FOR GRANTING THE WRIT

A. The proper characterization of the qualified immunity in the Health Care Quality Improvement Act is a previously undecided but important issue of federal law that immediately affects both the quality of health care and the cost of medical services available in American hospitals.

Dr. Decker has asserted only money damage claims in this case. Under HCQIA, there is an express, statutory presumption that such claims for damages under both state and federal law are barred by HCQIA immunity. See part B, infra. Petitioners' assertion of HCQIA immunity should have been handled by the district court in the same manner as a claim of qualified immunity by a government official in a civil rights case seeking money damages, and an interlocutory appeal should have been allowed by the court of appeals after the district court refused to recognize the HCQIA immunity. This Court has repeatedly held that the failure to recognize a legitimate claim of qualified immunity at the beginning of a lawsuit results in the loss to the defendants of the major benefit of such immunity, and thereby frustrates the public policy interest that the immunity is designed to promote. The right of interlocutory appeal is

considered necessary to prevent the loss of the benefit of immunity early in a lawsuit if a district court fails to recognize the effect of the immunity. See part C, infra.

This case involves issues under the federal Health Care Quality Improvement Act that are of exceptional public importance because they have an immediate impact on the quality and cost of health care available in American hospitals. In HCQIA, Congress has recognized that the threat of precisely this type of litigation deters physicians from performing in-hospital peer review. Congress recognized that such review is essential in order to maintain high quality health care in hospitals. Statutory immunity was enacted in HCQIA to reduce the threat of this kind of lawsuit and, thereby, to encourage peer review in order to maintain high quality health care. See part B,

below. These issues have never been considered by the U.S. Supreme Court.[7]

Delaying a decision on these issues while waiting for a conflict in opinions from the circuit courts will cause irreparable damage to what is already a very fragile peer review process involving physicians who, as the result of the "malpractice crisis," have a keen distrust for the legal system and a real and often exaggerated fear of litigation. By denying "immunity from suit" status to HCQIA immunity, by which retaliatory litigation could be meaningfully limited, the quality of health care will be jeopardized by incompetent physicians who no one will dare to effectively discipline. In addition, the cost of health care will increase because retaliatory lawsuits arising from peer review must

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7. Two opinions of this Court refer to HCQIA: Patrick v. Burget, 108 S. Ct. 1658, 1665 n. 8, reh. den. 487 U. S. 1243 (1988), and Summit Health Ltd. v. Pinhas, 111 S. Ct. 1842, 1848 n. 12 (1991).

be fully litigated, without the opportunity for early dismissal and immediate appeal that applies in other types of qualified immunity cases.

B. By erroneously refusing to allow an interlocutory appeal to challenge the district court's failure to recognize the HCQIA immunity, the court of appeals has erroneously undermined the national interest identified in HCQIA, namely that the Act's statutory qualified immunity is intended to provide meaningful incentive and protection from litigation for physicians and hospitals to encourage them to engage in vigorous and effective peer review.

In the statutory findings that are part of the Health Care Quality Improvement Act, Congress determined that:

(1) [M]edical malpractice and the need to improve the quality of medical care have become national problems ....

(2) There is a national need to restrict the ability of incompetent physicians to move from state to state ....

(3) This nationwide problem can only be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

42 USC Sec. 11101 [emphasis added].

Because of the highly specialized nature of medical training, the main quality assurance mechanism for physicians in the United States is review by their peers in various practice settings,

but principally through hospital medical staff organizations.[8] As in this case, such peer review is generally done by fellow physicians on a voluntary basis, without compensation. However, recent, widely publicized, retaliatory lawsuits against physicians for peer review activities, and multi-million dollar judgments in a few of those cases,[9] have greatly diminished the willingness of physicians to voluntarily risk such litigation in order to perform the unpaid and generally thankless task of peer review. Their fears are confirmed in the professional literature,[10] and have

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8. See Rep. Waxman's quotation, below.

9. E.g., Patrick v. Burget, 800 F. 2d 1498 (9th Cir. 1986), reversed 486 U. S. 94, reh. den. 487 U. S. 1243 (1988). The motivation for enacting HCQIA came largely from the response of physicians to the district court decision in Patrick. See part B below.

10. See, e.g., Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987): "[T]he effectiveness of peer-review performance monitoring has been greatly undermined by a

been elevated to a national concern by the statutory findings in HCQIA, quoted above.

The mechanism chosen by Congress to provide the needed "incentive and protection for physicians engaging in effective professional peer review" is the qualified immunity found in HCQIA.[11] The Act provides that, if certain specified procedural standards are satisfied (thus making the immunity qualified and not absolute),[12] then the facility, committee, and individuals conducting the peer review "shall not be liable in damages under

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genuine fear of retaliatory lawsuits brought by physicians who are the subjects of disciplinary action." See also, Iglehart, *Health Policy Report - Congress Moves to Bolster Peer Review: The Health Care Quality Improvement Act of 1986*, 316 New Eng. J. Med. 960 (1987).

11. The Act also provides for an award of attorneys fees in favor of defendants who prevail in this type of lawsuit. See, 42 USC Sec. 11113 (Appendix A).

12. HCQIA immunity is "qualified" both because of the procedural standards in the Act and because it expressly does not extend to civil rights actions, to actions by any state or federal attorney general, or to actions for only declaratory or injunctive relief. 42 USC Sec. 11111(a)(1).

any law of the United States or of any State ...." 42 USC Sec. 11111(a). For purposes of litigation, the conditions upon which the immunity depends are required by HCQIA to be presumed to exist, thereby further increasing the intended deterrence of retaliatory litigation. See, 42 USC Sec. 11112(a) (last sentence).

The legislative history of HCQIA confirms that the intention of Congress was to provide immunity of a kind that would lead to the early termination of most retaliatory lawsuits such as this one by Dr. Decker.

> To assure that the medical profession cooperates in this [peer review] system, the Committee believes it is essential to provide some legal immunity to doctors and hospitals that engage in peer review activities.
>
> Even though defendants may often win these lawsuits [by disciplined physicians], that may not be sufficient to guarantee

> enthusiastic, or even minimally adequate, peer review. Unlike other activities that may trigger antitrust lawsuits, properly limited peer review plays no essential or important economic role in the practice of medicine. Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review. The result would be to continue the possibilities for abuse by bad doctors.
>
> Thus, there is a clear need to do something to provide protection for doctors engaging in peer review if this reporting system is to be workable.[13] To that end, the bill provides limited, but essential, immunity.

H.R.Rep. No. 99-903, 99th Cong., 2d. Sess. 2, reprinted in 1987 U.S. Code Congressional and

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13. The HCQIA creates a "National Practitioner Data Bank" to keep track of physicians who have been disciplined for either incompetence or professional misconduct or for whom a payment has been made in response to a claim or judgment of medical malpractice. Hospitals and insurance companies are required to report such matters to the Data Bank, and hospitals are required to seek information from the Data Bank when credentialing and recredentialing physicians. See, 42 USC Sec.s 11131, 11135; 45 CFR Part 60 (1989).

Administrative News 6384-5 (herein referred to the "House Report," with reference to the U.S. Code Congressional and Administrative News page numbers). [Emphasis added.]

Of particular relevance is the stated Congressional intention that HCQIA litigation should be handled expeditiously by courts. The House Report makes it clear that Congress' intent was that courts would act promptly under the Act in order to minimize the misuse of the litigation process by physicians such as Dr. Decker who are seeking to use litigation to deter, intimidate, or disrupt hospital peer review activities. See the House Report at 6394:

> The Committee intends that these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. ... For example, a court might determine at an early state of litigation that the defendant has met

> the 102(a) standards [42 USC Sec. 11112(a)], even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity. [Emphasis added.]

When this congressional intent language to provide a means of early disposition of retaliatory lawsuits is coupled with the congressional findings of national need and the statutory language of immunity, it is clear that HCQIA immunity is intended to be the functional equivalent of the kind of qualified immunity applicable in other types of cases from which the interlocutory appeal in question would have been allowed.[14] See, e.g.,

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14. A law review commentator has reached the same conclusion, namely that the qualified immunity of government officials in civil rights actions provides an appropriate model for implementing the immunity intended by Congress in the HCQIA. See, Comment, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of its Protection*, 20 St. Mary's L. J. 955 (1989), at 975-79: "Qualified Immunity - Model for the HCQIA Protection."

Mitchell v. Forsyth, 472 U.S. 511 (1985), and compare Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc., 1993 LEXIS 830, 61 U.S.L.W. 4045 (January 12, 1993). See part C, below.

C. The policy behind HCQIA qualified immunity is essentially the same as the policy supporting qualified immunity in other contexts, and the petitioners' appeals should have been allowed as they would have been in other types of qualified immunity cases.

The language and intent behind the immunity in HCQIA, as set forth in part B. above, very closely parallel the reasons for the qualified immunity exception to the collateral order rule that allows an immediate appeal from an order denying an assertion of absolute or qualified immunity by a government official. See, Harlow v. Fitzgerald, 457 U.S. 800, 102 S.Ct. at 2736, 2738 (1982):

> The resolution of immunity questions inherently involves a balance between the evils inevitable in any available alternative. ... At the same time, however, it cannot be disputed seriously that claims frequently run against the innocent as well as the guilty - at a cost not only to the defendant officials, but to society as a whole. These social costs include the expenses of litigation, the diversion of official energy from pressing public issues, and the deterrence of able citizens from acceptance of public office. Finally, there is the danger that fear of being sued will "dampen the ardor of all but the most resolute, or the most irresponsible [public officials], in the unflinching discharge of their duties." [Citation omitted.]
>
> In identifying qualified immunity as the best attainable accommodation of competing values, [citations omitted], we relied on the assumption that this standard would permit "[i]nsubstantial lawsuits [to] be quickly terminated." [Emphasis added.]

And see, Mitchell v. Forsyth, 472 U.S. 511, 105 S.Ct. 2806, 2815 (1985): "The conception animating the

qualified immunity doctrine as set forth in Harlow, is that 'where an official's duties legitimately require action in which clearly established rights are not implicated, the public interest may be better served by action taken 'with independence and without fear of consequences.' " [Citations omitted.] [Emphasis added.] Interlocutory appeals are allowed in such circumstances to immediately challenge the denial of asserted immunity because the benefit of immunity is "effectively lost if a case is erroneously permitted to go to trial." Mitchell, 105 S. Ct. at 2815.

The comments of the floor leader for the deliberations on HCQIA in the House of Representatives are very clear on what the consequence would be of not providing effective immunity for the participants in physician peer

review in hospitals, especially given the national reporting requirements of the Act:[15]

> Doctors who engage in peer review do so as volunteers, not to make money from their activities. If they face years of litigation with the prospect of having to pay enormous litigation fees as well as treble damages assessed against them personally, they simply will not do peer review. Moreover, peer review stands as the primary basis upon which this country reviews the competence and professional conduct of doctors. Until a different or better system is devised, we must take every reasonable step to ensure its success.

132 Cong. Rec. H11588 (daily ed. October 17, 1986) (statement of Rep. Waxman) (emphasis added).

Very recently, this Court has reinforced these grounds in a context relevant to this case, namely the distinction between "immunity from suit" and "immunity from liability." See, Puerto Rico

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15. See note 13, above.

Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc., 1993 LEXIS 830, 61 U.S.L.W. 4045 (January 12, 1993): "[T]he value to the States of their Eleventh Amendment immunity, like the benefit conferred by qualified immunity to individual officials, is for the most part lost as litigation proceeds past motion practice."

Thus, the public policy reasons that have given rise to qualified immunity in other contexts and have required immediate appealability of orders that fail to recognize such qualified immunity, precisely parallel the reasons stated by Congress in the HCQIA findings and legislative history as the reasons for the immunity in HCQIA. The court of appeals has erred in requiring different procedural treatment for HCQIA immunity.

D. The basis of the decision of the court of appeals is inconsistent with the characterization of HCQIA by this Court in Summit Health Ltd. v. Pinhas.

By applying a strained interpretation of HCQIA, wherein its grant of immunity was characterized as "immunity from liability" but not "immunity from suit," the court of appeals denied interlocutory appealability of motions to dismiss that assert HCQIA immunity. This interpretation is inconsistent with the interpretation applied to HCQIA by this Court in Summit Health Ltd. v. Pinhas, 111 S. Ct. 1842, 1848 n. 12 (1991): "The [Health Care Quality Improvement Act] provides for immunity from antitrust, and other, actions if the peer review process proceeds in accordance with [42 USC Sec. 11112]." [Emphasis added.]

Thus, the court of appeals' conclusion that HCQIA immunity is not "immunity from suit" is

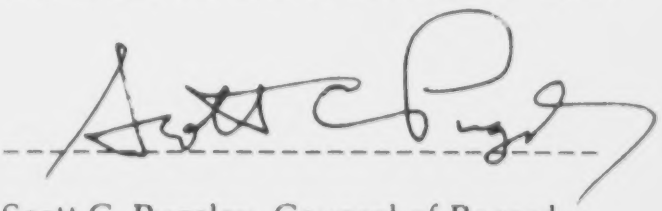
inconsistent with this Court's only characterization of that Act as "immunity from ... [state and federal damage claim] actions." The consequences of not following this Court's characterization of HCQIA is the loss of precisely the public policy benefit that Congress intended would result from HCQIA immunity, namely the encouragement of effective peer review designed to catch and deal with physicians who cause or threaten harm to hospital patients, free from the expense of defending retaliatory lawsuits.

CONCLUSION

This case directly impacts both the quality and the cost of available health care in American hospitals. The decision of the court of appeals has removed from HCQIA the intended immunity from suit for good faith peer review that Congress believed was necessary to encourage such peer

review. Limiting HCQIA immunity to a "immunity from liability" only, which is a "mere defense," erroneously weakens the Act's intended "protection" and completely removes the desired incentive. Unless the decision of the court of appeals is reversed so that defendants in this kind of lawsuit can challenge early denials of claimed immunity, physicians and hospitals simply will not do effective physician peer review that may result in an expensive, time consuming retaliatory lawsuit by a disciplined physician.

The Court is respectfully requested to grant this petition and to review the decision of the court of appeals.



Scott C. Pugsley, Counsel of Record

Appendix A

The Health Care Quality Improvement Act of 1986, as amended ("HCQIA").

42 USC Sec. 11101 et seq. (excerpts)

[All emphasis added.]

42 USC Sec. 11101. FINDINGS.

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) **The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.**

(5) **There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.**

42 USC Sec. 11111. PROFESSIONAL REVIEW.

(a) In General. -

(1) Limitation on Damages for Professional Review Actions. - If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section -

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil RIghts Act of 1964, 42 U.S.C. 2000e et seq. and the Civil RIghts Acts, 42 U.S.C. 1981 et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act, 15 U.S.C.

Sec. 15C where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies. Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) Exception. If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary [of Health and Human Services] shall conduct an investigation. If, after

providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care provider has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) of the section shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) Treatment Under State Laws. [Omitted.]

42 USC Sec. 11112. STANDARDS FOR PROFESSIONAL REVIEW ACTIONS.

(a) In General. For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken -

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title

unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate Notice and Hearing. A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action.

The physician has been given notice stating--

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing.

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice.

If a hearing is requested on a timely basis under paragraph (1)(B)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

(c) Adequate Procedures in Investigations or Health Emergencies. For purposes of section 11111(a) of this title, nothing in this section shall be construed as -

(1) requiring the procedures referred to in subsection (a)(3) of this section -

(A) where there is not adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for period of not longer than 14 days, during which an investigation

is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 USC Sec. 11113. PAYMENT OF REASONABLE ATTORNEYS FEES AND COSTS IN DEFENSE OF SUIT.

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such

claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

42 USC Sec. 11114. CONSTRUCTION.

(a) In General. Except as specifically provided in this part, nothing in this part shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides **incentives, immunities, or protection for those engaged in a professional review action** that is in addition to or greater than that provided by this part.

[Balance of section omitted.]

Appendix B

PUBLISH

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

JOSEPH F. DECKER,	)	
	)	
Plaintiff-Appellee,	)	
	)	
v.	)	
	)	No. 91-4160
	)	No. 91-4161
	)	
IHC HOSPITALS, INC., and CHARLES L. DOANE, MERRILL C. DAINES, LEE S. BROADBENT, ROBERT L. JENSEN, C. CHRIS FRIESS, and CHARLES T. SWALLOW,	)	**FILED** United States Court of Appeals Tenth Circuit Dec 29 1992 Robert L. Hoecker Clerk
	)	
	)	
	)	
Defendants-Appellants.	)	
	)	

UTAH HOSPITAL ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION and UTAH MEDICAL ASSOCIATION,	)
	)
Amici Curiae.	)

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH
(D.C. No. 91-C-424 G)

James W. Gilson (Scott C. Pugsley, of IHC Hospitals, Inc.; Richard W. Casey, of Giauque, Crockett & Bendinger; and Charles W. Dahlquist, II, Merrill F. Nelson, and David B. Erickson, of Kirton, McConkie & Poelman; all of Salt Lake City, Utah, with him on the briefs), of IHC Hospitals, Inc., Salt Lake City, Utah, for the Defendants-Appellants.

David K. Isom (Curtis R. Hussey, of David K. Isom & Associates, Salt Lake City, Utah, with him on the brief), of David K. Isom & Associates, Salt Lake City, Utah, for the Plaintiff-Appellee.

Fredric J. Entin, Ila S. Rothschild, and Jeffrey M. Teske, of the American Hospital Association, Chicago, Illinois; Don B. Allen and Jonathan A. Dibble, of Ray, Quinney & Nebeker, of Salt Lake City, Utah; Virginia H. Hackney, John Charles Thomas, and R. Hewit Pate, of Hunton & Williams, Richmond, Virginia; and Elliott J. Williams, of

Williams & Hunt, Salt Lake City, Utah, for the Amici Curiae.

Before TACHA and McWILLIAMS, Circuit Judges, and O'CONNOR, District Judge. [Honorable Earl E. O'Connor, Senior District Judge, United States District Court for the District of Kansas, sitting by designation.]

TACHA, Circuit Judge.

Defendants appeal a district court order denying their Rule 12(b)(6) motions to dismiss on the grounds of statutory immunity and plaintiff's failure to exhaust his administrative remedies. We dismiss the appeal for lack of appellate jurisdiction.

Dr. Joseph F. Decker initiated this action after the Logan Regional Hospital restricted his clinical privileges. He names as defendants the hospital's owner, IHC Hospitals, Inc., the hospital's

administrator, Charles Doane, and five doctors who participated in the peer review process that led to the restriction of his privileges: Drs. Daines, Broadbent, Jensen, Friess, and Swallow ("Physician Defendants"). In his amended complaint, Dr. Decker asserts twelve claims for relief alleging the breach of various contractual and common law tort duties; violations of the Sherman Act, RICO, and the federal extortion statute; violations of similar Utah statutes; and conspiracy to deprive Dr. Decker of his civil rights in violation of 42 U.S.C. §1985. He seeks compensatory, treble, and punitive damages, as well as costs and attorneys fees.

All defendants moved pursuant to Rule 12(b)(6) to dismiss the case on two grounds: (1) Dr. Decker failed to exhaust his administrative remedies under the hospital's bylaws; and (2) the defendants are immune from liability under the Health Care Quality Improvement Act of 1986

(HCQIA), 42 U.S.C. §§ 11101-52. The Physician Defendants moved separately to dismiss on the additional ground that they are immune from liability under the Utah Medical Practices Act (Utah MPA), Utah Code Ann. §§58-12-26 to -43 (1990 & Supp. 1992).

The district court denied without prejudice both motions to dismiss. All the defendants appealed the denial of the motion to dismiss based on the exhaustion doctrine and the HCQIA. The Physician Defendants appealed the dismissal of their motion to dismiss based on the Utah MPA. The appeals were consolidated.

Dr. Decker filed with this court a motion to dismiss for lack of appellate jurisdiction.[1] He argues that the district court order denying the

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[1] Dr. Decker filed his motion more than 15 days after the defendants filed their notices of appeal. Although we favor the practice of filing motions to dismiss for lack of appellate jurisdiction within 15 days after the notice of appeal is filed, see 10th Cir. R. 27.2.1, we will consider the merits of Dr. Decker's motion.

motions to dismiss is not a "final" order that is appealable under 28 U.S.C. §1291. The defendants argue that the HCQIA establishes immunity from suit and therefore the collateral order doctrine, as applied in Mitchell v. Forsyth, 472 U.S. 511 (1985), permits immediate appeal in this case. The Physician Defendants argue that the Utah MPA also establishes immunity from suit and therefore permits immediate appeal. We hold that neither the HCQIA nor the Utah MPA establishes immunity from suit, and we therefore dismiss the appeal.[2]

In general, an order denying a motion to dismiss is not final because it "ensures that litigation will continue in the District Court." Gulfstream Aerospace Corp. v. Mayacamas Corp.,

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[2] Because we hold that the order denying the motions to dismiss on the grounds of immunity is not appealable, we need not address defendants' contention that we have pendent appellate jurisdiction over the exhaustion of remedies issue.

485 U.S. 271, 275 (1988). Such an order is therefore not appealable unless it falls within the small class of orders that are final for purposes of §1291 under the collateral order doctrine established in Cohen v. Beneficial Industrial Loan Corp., 337 U.S. 541 (1949). The Supreme Court has articulated a three-pronged test to determine whether an order that does not finally resolve a case is nonetheless appealable under the collateral order doctrine:

> First, the order must "conclusively determine the disputed question." Second, the order must "resolve an important issue completely separate from the merits of the action." Third and finally, the order must be "effectively unreviewable on appeal from a final judgment." If the order at issue fails to satisfy any one of those requirements, it is not appealable under the collateral order exception to §1291.

Gulfstream Aerospace, 485 U.S. at 276 (citations omitted) (quoting Coopers & Lybrand v. Livesay, 437 U.S. 463, 468 (1978)).

In Mitchell v. Forsyth, the Supreme Court held that a district court order denying a government official's motion to dismiss that is grounded on an assertion of the qualified immunity established in Harlow v. Fitzgerald, 457 U.S. 800 (1982), is immediately appealable under the Cohen doctrine. Mitchell, 472 U.S. at 530. The court reasoned that because Harlow provides "an immunity from suit rather than a mere defense to liability," Id. at 526, the denial of a motion to dismiss meets each prong of the Cohen test. Most importantly, the court concluded that such an order meets the third prong because the immunity from suit "is effectively lost if a case is erroneously permitted to go to trial." Id.

Federal courts thus permit appeals of orders denying motions to dismiss where the motions are based on immunity from suit. See, e.g., Helstoski v. Meanor, 442 U.S. 500 (1979) (holding that the Speech and Debate Clause establishes immunity from suit and permitting immediate appeal); Abney v. United States, 431 U.S. 651 (1977) (holding that the Double Jeopardy Clause establishes immunity from suit and permitting immediate appeal); Eng v. Coughlin, 858 F. 2d 889 (2d Cir. 1988) (holding that the 11th Amendment establishes immunity from suit and permitting immediate appeal). Where, however, the basis of the motion to dismiss is not an immunity from suit, the courts hold that an order denying the motion is not immediately appealable. See, e.g., Lauro Lines S.R.L. v. Chasser, 490 U.S. 495 (1989) (holding that a contractual forum selection clause did not establish immunity from suit and affirming dismissal of appeal); Van

Cauwenberghe v. Biard, 486 U.S. 517 (1988) (holding that immunity from civil process does not constitute immunity from suit and affirming dismissal of appeal); Brown v. Grabowski, 922 F. 2d 1097 (3d Cir. 1990) (holding that the New Jersey Tort Claims Act does not establish immunity from suit and dismissing appeal), cert. denied, 111 S. Ct. 2827 (1991); Marrical v. Detroit News, Inc., 805 F. 2d 169 (6th Cir. 1986) (Holding that Michigan's common law doctrine of absolute or qualified immunity does not include immunity from suit and dismissing appeal).

And the Supreme Court recently summarized, "[t]he critical question, following Mitchell, is whether 'the essence' of the claimed right is a right not to stand trial." Van Cauwenberghe, 486 U.S. at 524. Apart from the common law absolute and qualified immunities from suit enjoyed by some government officials,

"[a] right not to be tried in the sense relevant to the Cohen exception rests upon an explicit statutory or constitutional guarantee that trial will not occur." Midland Asphalt Corp. v. United States, 489 U.S. 794, 801 (1989) (emphasis added). Thus, the key question in this case is whether the HCQIA and the Utah MPA explicitly immunize the defendants from suit.

We conclude that the HCQIA establishes an immunity from liability only. The section of the HCQIA entitled "Limitations on damages for professional review actions" provides in pertinent part:

> If a professional review action . . . of a professional review body meets all the standards specified in section 11112(a) of this title . . .
>
> (A) the professional review body,
>
> (B) any person acting as a member or staff to the body,

> (C) any person under a contract or other formal agreement with the body, and
>
> (D) any person who participates with or assists the body with respect to the action,
>
> shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

42 U.S.C. §11111 (a)(1) (emphasis added). The plain meaning of this provision is that professional review bodies and covered individuals who satisfy the requirements of §11112 (a)[3] are immune from

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[3] Section 11112 (a) provides in full:

For purposes of the protection set forth in section 11111 (a) of this title, a professional review action must be taken - -

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111 (a) of this title unless the presumption is

liability only. On its face, this provision does not explicitly establish immunity from suit.

The HCQIA's legislative history supports our conclusion that the act establishes immunity from liability only. The HCQIA was originally introduced as H.R. 5110, 99th Cong., 2d Sess. (1986). That bill contained the following provision similar to 42 U.S. C. §11111 (a)(1):

> If a professional review action . . . of a professional review body meets the standards specified in section 102(a), . . .
>
> (1) the professional review body,
>
> . . .
>
> shall not be subject to an action or liable under any Federal Law and, subject to subsection (c), under any State Law, with respect to the action.

H.R. 5110 §101 (a) (emphasis added). Thus, the act as originally drafted would have established an

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rebutted by a preponderance of the evidence.

immunity from suit. After considering H.R. 5110, however, the House Committee on Energy and Commerce amended the section establishing immunity and resubmitted the bill as H.R. 5540. See H.R. Rep. No. 903, 99th Cong., 2d Sess. 3-4 (1986), reprinted in 1986 U.S.C.C. A. N. 6384, 6386. The Committee explained that

> [i]nitially [it] considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill.

id. at 9, reprinted in 1986 U.S.C.C.A.N. at 6391 (emphasis added). The section of H.R. 5540 that established immunity from liability was passed

without substantive amendment and is now codified at 42 U.S.C. §11111 (a). See H.R. 5540, 99th Cong., 2d Sess. §101(a) (1986). Thus, the legislative history of the HCQIA supports our conclusion that §11111 (a)(1) establishes immunity from liability only.

We likewise conclude that the Utah MPA does not establish immunity from suit. Section 58-12-43(8) of the Utah MPA provides:

> An individual who is a member of a hospital administration, board, committee, department, medical staff, or professional organization of health care providers as defined in Section 78-14-3 is immune from liability arising from participation in a review of a health care provider's professional ethics, medical competence, moral turpitude, or substance abuse.

Utah Code Ann. §58-12-43(8) (Supp. 1992) (emphasis added). On its face, this provision does not

explicitly establish immunity from suit. We have discovered no case interpreting this provision to establish immunity from suit, nor have the Physician Defendants directed us to any statements in the Utah MPA's legislative history that would counter our conclusion. In the absence of "an explicit statutory . . . guarantee that trial will not occur," Midland Asphalt, 489 U.S. at 801, we must conclude that the Utah MPA does not establish an immunity from suit.

Because neither the HCQIA nor the Utah MPA provides "an immunity from suit rather than a mere defense to liability," Mitchell, 472 U.S. at 526, the district court order fails to meet the third prong of the Cohen test. The defendants have no right to be free from trial, and their asserted right to be free from liability can be effectively vindicated in a future appeal of a final order. We therefore hold

that the district court order denying the defendants' motions to dismiss is not immediately appealable.

APPEAL DISMISSED.

Appendix C

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

JOSEPH F. DECKER,	)	
	)	
Plaintiff-Appellee,	)	
	)	
v.	)	
	)	No. 91-4160
	)	No. 91-4161
	)	
IHC HOSPITALS, INC., and CHARLES L. DOANE, MERRILL C. DAINES, LEE S. BROADBENT, ROBERT L. JENSEN, C. CHRIS FRIESS, and CHARLES T. SWALLOW,	)	Robert L. Hoecker Clerk
	)	
Defendants-Appellants.	)	
	)	

ORDER

Filed February 11, 1993

Before McKAY, Chief Judge, McWILLIAMS, LOGAN, SEYMOUR, MOORE, TACHA, BALDOCK, BRORBY, EBEL, KELLY, Circuit Judges, and O'CONNOR,* District Judge.

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* The Honorable Earl E. O'Connor, United States District Judge for the District of Kansas, sitting by designation.

This matter comes on for consideration of appellants' petition for rehearing and suggestion for rehearing in banc.

Upon consideration whereof, the petition for rehearing is denied by the panel of judges who rendered the decision sought to be reheard.

In accordance with Rule 35(b) of the Federal Rules of Appellate Procedure, the suggestion for rehearing in banc was transmitted to all the judges of the court who are in regular active service. No member of the panel and no judge in regular active service on the court having requested that the court be polled on rehearing in banc, Rule 35, Federal Rules of Appellate Procedure, the suggestion for

rehearing in banc is denied. Judge Anderson is recused from this case.

Entered for the Court

ROBERT L. HOECKER, Clerk

By: /s/
Barbara Schermerhorn
Deputy Clerk